Open Arms Client Referral Form

2500 Bloomington Ave, Minneapolis, MN 55404
Phone (612) 767-7333 || Fax (612) 872-0866

Client Information:

Name: First _____ **Middle** _____ **Last** _____

Address: _____ **Apt:** _____

City: _____ **Zip Code:** _____ **County:** _____

Primary Phone: (_____) -_____ **Other Phone:** (_____) - _____

Date of Birth: _____ / _____ / _____ **Email:** _____

Client Consent for Release of Information

I understand that any information about me provided to Open Arms of Minnesota is confidential and will not be disclosed without my consent in this release. I authorize my health care provider or case manager listed below on Page 2 to verify my health information for Open Arms of Minnesota and share information about me that is relevant to this service. I understand that my information may be reported to funding sources, but will be treated with the utmost privacy. This release will remain in effect for a year from the date below unless revoked in writing.

Client Signature_____ **Date**_____

Individuals are eligible for Open Arms Services if they are living with HIV/AIDS, Multiple Sclerosis, ESRD, COPD, CHF, ALS, or are in acute treatment for cancer. Please contact Open Arms **before** completing this form if your client has another primary diagnosis, or has completed cancer treatment but is in need of meal deliveries.

Diagnosis: (*Please check all that apply*)

- ☐ HIV/AIDS
- ☐ ALS
- ☐ MS
- ☐ ESRD (On Dialysis)
- ☐ CHF
- ☐ COPD
- ☐ Cancer: Type _____
  - ☐ Chemotherapy: Start ____/____/____ End ____/____/____
  - ☐ Radiation: Start ____/____/____ End ____/____/____
  - ☐ Surgery: Date: ____/____/____ (Estimated recovery time: _____ weeks)
- ☐ Other: _____

Please state reason for referral. Other illnesses are subject to approval by OAM staff. _____

_____

_____

_____

Please indicate if client has **other diagnoses** that require a special diet/affects their eating:

☐ Diabetes ☐ Mental health diagnosis ☐ High blood pressure
☐ High cholesterol ☐ Other *(specify)* _____

Height (in.) _____ **Weight (lbs.)** _____ **BMI** _____ **Date Taken:** _____

Please list any special dietary needs/allergies: _____

Have you lost weight within the last 6 months without trying? ☐ No ☐ Yes (If Yes, How Much?) _____

Have you been eating poorly due to decreased appetite? ☐ Yes ☐ No

Do you struggle with nausea or vomiting? ☐ Yes ☐ No

Would you like one of our Dietitians to reach out to you? ☐ Yes ☐ No

Hospitalization(s) in the past 6 months:

Date	Reason	Medical Center

DEMOGRAPHIC DETAILS:

Insurance Information: ☐Medicare A/B ☐Medicare D ☐Medicaid, CHIP, Other Public
☐Private (Employer_____ Individual ____) ☐VA, Tricare, Other military Healthcare ☐Indian Health Service
☐Other Insurance (specify)_____ ☐No Insurance

Gender: ☐Male ☐Female ☐Transgender Male to Female ☐Transgender Female to Male ☐Gender Unknown

Country of Birth: ☐ U.S.A. ☐ Other (*please specify*) _____ ☐ Unknown

Race: (Check all that apply)

☐ American Indian/Alaska Native
☐ Asian (☐Asian Indian ☐Chinese ☐Filipino ☐Japanese ☐Korean ☐Vietnamese ☐Other Asian)
☐ Black
☐ Native Hawaiian/Pacific Islander (☐Native Hawaiian ☐Guamanian/Chamorro ☐Samoan ☐Other Pacific Islander)
☐ White

Ethnicity: ☐Hispanic (☐Mexican ☐Puerto Rican ☐Cuban ☐Other Hispanic) ☐Non-Hispanic

Primary Language: ☐ English ☐ Other (*please specify)* _____ Interpreter Needed? ☐

Living Situation: ☐ Stable ☐ Unstable ☐ Temporary

Total Household Income: $ _____ (per year) or $ _____ (per month)

Number in Household Supported by Income (including client): _____

Is the client eligible for reimbursement for meals through CADI or elderly waivers? ☐Yes ☐No ☐Don't know

Name of CADI/Waiver Case Manager (if applicable): _____

CADI/Waiver Case Manager Phone #: _____

For HIV+ Clients Only:

We need the following information from HIV+ clients as a requirement of a federal grant. We will ask for proof of income, residence, and insurance twice a year.

Date of client's residency in Minnesota: ____/____/_____ **Check here if client was born in Minnesota:** ☐

Diagnosis: ☐HIV+, no AIDS diagnosis ☐CDC Defined AIDS ☐HIV+ AIDS diagnosis unknown
Date of HIV diagnosis ____/____/_____ Date of AIDS diagnosis (if applicable) ____/____/_____

Medical: Date of Most Recent HIV Apt _____ HIV Viral load _____ cD4 cell count _____

Exposure: ☐Male/Male Sex ☐Heterosexual Contact ☐Receipt of blood (transfusion, components, or tissue)
☐Injecting Drug Use ☐Hemophilia/Coagulation disorder ☐Unknown

Client must attach proof of income, residence and insurance. (*Please check what forms of documentation are attached.)*

Income: ☐Recent Pay Stub ☐Benefit Statement ☐Recent Tax Return ☐Statement of Zero Income ☐ Other
Residence: ☐Copy of Driver's License ☐Benefit Statement ☐Utility Bill ☐Other
Insurance: ☐Copy of Insurance Card ☐Benefit Statement ☐Other

For Referrers Only: I verify this person's diagnosis and need for service.

Name & Title: _____ Organization: _____

Fax: (_____) - _____ Phone: (_____) -_____

Address: _____ Email:_____

Referrer Signature: _____ Today's Date: _____